		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026716

Facility Name: Robings Manor Nursing Home

Address: 502 North Main Street (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

Telephone Number: (618) 372-3232 **Fax #** (618) 372-7117

IDPA ID Number: 371068286004

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[x]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,989	6,708		23,697	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13

D. How many bed-hold days during this year were paid by Public Aid?
113 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

14	TOTALS	16,989	6,708		23,697	14	Is your fiscal year identical to your tax year? YES [x] NO [ ]

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.48%

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	88,477	8,231	653	97,361		97,361	21	97,382			1
2	Food Purchase		85,781		85,781		85,781	(3,780)	82,001			2
3	Housekeeping	66,699	7,860		74,559		74,559		74,559			3
4	Laundry	18,321	6,470		24,791		24,791		24,791			4
5	Heat and Other Utilities			49,678	49,678		49,678	389	50,067			5
6	Maintenance	24,210	33,704	1,629	59,543		59,543	476	60,019			6
7	Other (specify):*											7
8	**TOTAL General Services**	197,707	142,046	51,960	391,713		391,713	(2,894)	388,819			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	565,318	17,943	900	584,161		584,161		584,161			10
10a	Therapy			2,700	2,700		2,700		2,700			10a
11	Activities	15,633	520	3,008	19,161		19,161		19,161			11
12	Social Services	29,252	862	780	30,894		30,894	4	30,898			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	610,203	19,325	15,188	644,716		644,716	4	644,720			16
	C. General Administration											
17	Administrative	138,046		47,891	185,937		185,937	(47,891)	138,046			17
18	Directors Fees											18
19	Professional Services			18,189	18,189		18,189	3,270	21,459			19
20	Dues, Fees, Subscriptions & Promotions			5,239	5,239		5,239	219	5,458			20
21	Clerical & General Office Expenses	22,747	5,030	11,930	39,707		39,707	9,405	49,112			21
22	Employee Benefits & Payroll Taxes			147,112	147,112		147,112	12,096	159,208			22
23	Inservice Training & Education			1,218	1,218		1,218	43	1,261			23
24	Travel and Seminar			9,611	9,611		9,611	1,267	10,878			24
25	Other Admin. Staff Transportation			2,356	2,356		2,356	1,413	3,769			25
26	Insurance-Prop.Liab.Malpractice			37,864	37,864		37,864	1,753	39,617			26
27	Other (specify):*											27
28	**TOTAL General Administration**	160,793	5,030	281,410	447,233		447,233	(18,425)	428,808			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	968,703	166,401	348,558	1,483,662		1,483,662	(21,315)	1,462,347			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Robings Manor Nursing Home #0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			45,799	45,799		45,799	6,785	52,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,296	115,296		115,296	931	116,227			32
33	Real Estate Taxes			9,190	9,190		9,190		9,190			33
34	Rent-Facility & Grounds							2,450	2,450			34
35	Rent-Equipment & Vehicles			6,486	6,486		6,486	1,706	8,192			35
36	Other (specify):*											36
37	**TOTAL Ownership**			176,771	176,771		176,771	11,872	188,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):* **Nonallowable costs**			4,658	4,658		4,658	(4,658)				43
44	**TOTAL Special Cost Centers**			41,888	41,888		41,888	(4,658)	37,230			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	968,703	166,401	567,217	1,702,321		1,702,321	(14,101)	1,688,220			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,083)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,002	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,575)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	50	43		24
25	Fund Raising, Advertising and Promotional	(805)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(3,864)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,520)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,581)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,581)		36
37	**(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))**	$ (14,101)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OHF USE ONLY									
48		49		50		51		52	

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home

ID# 0026716

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23

24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor Nursing Home # 0026716 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	21	0	0	0	0	0	0	0	0	0	21	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	389	0	0	0	0	0	0	0	0	0	389	5
6	Maintenance	0	476	0	0	0	0	0	0	0	0	0	476	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	886	0	0	0	0	0	0	0	0	0	886	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	4	0	0	0	0	0	0	0	0	0	4	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	(47,891)	0	0	0	0	0	0	0	0	0	(47,891)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,270	0	0	0	0	0	0	0	0	0	3,270	19
20	Fees, Subscriptions & Promotions	0	303	0	0	0	0	0	0	0	0	0	303	20
21	Clerical & General Office Expenses	0	9,405	0	0	0	0	0	0	0	0	0	9,405	21
22	Employee Benefits & Payroll Taxes	0	12,096	0	0	0	0	0	0	0	0	0	12,096	22
23	Inservice Training & Education	0	43	0	0	0	0	0	0	0	0	0	43	23
24	Travel and Seminar	0	1,267	0	0	0	0	0	0	0	0	0	1,267	24
25	Other Admin. Staff Transportation	0	1,413	0	0	0	0	0	0	0	0	0	1,413	25
26	Insurance-Prop.Liab.Malpractice	0	1,753	0	0	0	0	0	0	0	0	0	1,753	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(18,341)	0	0	0	0	0	0	0	0	0	(18,341)	28

29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	**0**	**(17,451)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(17,451)**	**29**

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Robings Manor Nursing Home **#** 0026716 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,002	0	5,783	0	0	0	0	0	0	0	0	6,785	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	931	0	0	0	0	0	0	0	0	931	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,450	0	0	0	0	0	0	0	0	2,450	34
35	Rent-Equipment & Vehicles	0	0	1,706	0	0	0	0	0	0	0	0	1,706	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,002	0	10,870	0	0	0	0	0	0	0	0	11,872	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,658)	0	0	0	0	0	0	0	0	0	0	(4,658)	43
44	**TOTAL Special Cost Centers**	(4,658)	0	0	0	0	0	0	0	0	0	0	(4,658)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,656)	(17,451)	10,870	0	0	0	0	0	0	0	0	(10,237)	45

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	100.00%	See attached schedule		See attached schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	100.00%	$ 21	$ 21	1
2	V	5	Utilities		Petersen Health Care Companies	100.00%	389	389	2
3	V	6	Maintenance supplies		Petersen Health Care Companies	100.00%	476	476	3
4	V	12	Social Services		Petersen Health Care Companies	100.00%	4	4	4
5	V	17	Administrative	47,891	Petersen Health Care Companies	100.00%		(47,891)	5
6	V	19	Professional services		Petersen Health Care Companies	100.00%	3,270	3,270	6
7	V	20	Dues, subscriptions, fees		Petersen Health Care Companies	100.00%	303	303	7
8	V	21	Clerical & general office expense		Petersen Health Care Companies	100.00%	9,405	9,405	8
9	V	22	Employee benefits		Petersen Health Care Companies	100.00%	12,096	12,096	9
10	V	23	Inservice training & education		Petersen Health Care Companies	100.00%	43	43	10
11	V	24	Travel & seminar		Petersen Health Care Companies	100.00%	1,267	1,267	11
12	V	25	Other admin staff transportation		Petersen Health Care Companies	100.00%	1,413	1,413	12
13	V	26	Insurance-prop, liability, malp		Petersen Health Care Companies	100.00%	1,753	1,753	13
14	Total			$ 47,891			$ 30,440	$ * (17,451)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen Health Care Companies	100.00%	$ 5,783	$ 5,783	15
16	V	32	Interest		Petersen Health Care Companies	100.00%	931	931	16
17	V	34	Rent - Facility and grounds		Petersen Health Care Companies	100.00%	2,450	2,450	17
18	V	35	Rent - Equipment and vehicles		Petersen Health Care Companies	100.00%	1,706	1,706	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,870	$ * 10,870	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	Secretary	Administrative	0.00	219,468	5	8.33	Salary	$ 26,082	L17, C1	1
2	James Petersen	President	Administrative	100.00	505,879	5	8.33	Salary	60,120	L17, C1	2
3	Todd Petersen	Administration	Administrative	0.00	63,756	5	8.33	Salary	7,577	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 93,779		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309)691-8113
Fax Number: (309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient days	223,096	8	$ 200	$	23,697	$ 21	1
2	5	Utilities	Patient days	223,096	8	3,666		23,697	389	2
3	6	Maintenance supplies	Patient days	223,096	8	4,490		23,697	477	3
4	10	Nursing	Patient days	223,096	8	40		23,697	4	4
5	19	Professional services	Patient days	223,096	8	30,834		23,697	3,275	5
6	20	Dues, subscriptions, fees	Patient days	223,096	8	2,859		23,697	304	6
7	21	Clerical & general office exp	Patient days	223,096	8	88,667		23,697	9,418	7
8	22	Employee benefits	Patient days	223,096	8	114,040		23,697	12,113	8
9	23	Inservice training & education	Patient days	223,096	8	402		23,697	43	9
10	24	Travel & seminar	Patient days	223,096	8	11,946		23,697	1,269	10
11	25	Other admin staff transportation	Patient days	223,096	8	13,319		23,697	1,415	11
12	26	Insurance - prop, liability, malp	Patient days	223,096	8	16,524		23,697	1,755	12
13	30	Depreciation	Patient days	223,096	8	54,520		23,697	5,791	13
14	32	Interest	Patient days	223,096	8	8,774		23,697	932	14
15	34	Rent - grounds & facility	Patient days	223,096	8	23,100		23,697	2,454	15
16	35	Rent - equipment	Patient days	223,096	8	16,083		23,697	1,708	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 389,464	$		$ 41,368	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Bank		x	Mortgage	$10,800.00	11/27/00	$ 1,020,000	$ 981,596	01/01/04	0.0975	$ 97,844	1
2	Bank of Farmington		x	Purchase of van	$761.65	08/10/99	45,000	24,373	08/10/04	0.0775	1,583	2
3												3
4												4
5												5
	Working Capital											
6	Peoples National Bank		x	Home Office Line of Credit				Interest only		0.1000	14,707	6
7												7
8												8
9	TOTAL Facility Related				$11,561.65		$ 1,065,000	$ 1,005,969			$ 114,134	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,162	10
11								Home office allocation			931	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,093	14
15	TOTALS (line 9+line14)						$ 1,065,000	$ 1,005,969			$ 116,227	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 8,581	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 8,886	2
3. Under or (over) accrual (line 2 minus line 1).		$ 305	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 8,885	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 9,190	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	7,690	8
	1997	8,107	9
	1998	8,726	10
	1999	8,581	11
	2000	8,886	12

Real estate tax accrual based on 100% of the prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an**

application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Nursing Home COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-001-047-00	N PT Lot 12 Albro Palmers Eral Sub D	$ 3,940.00	$ 3,940.00
2.	21-001-048-00	N PT Lot 13 Albro Palmers Eral Sub D	$ 4,945.00	$ 4,945.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,885.00	$ 8,885.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	42,108	1977	$ 25,000	1
2					2
3	TOTALS	42,108		$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1977	1977	$ 340,200	$ 14,878	25	$ 13,608	$ (1,270)	$ 338,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	357		20			357	9
10	Various			1979	62,800	2,512	25	2,512		57,776	10
11	Various			1983	27,383					27,383	11
12	Various			1984	3,788	102	20		(102)	3,788	12
13	Various			1985	4,563	192	20	228	36	4,689	13
14	Various			1989	6,368	202	20	318	116	4,961	14
15	Various			1991	5,525	175	20	276	101	3,421	15
16	Various			1992	14,285	454	20	714	261	6,914	16
17	Various			1995	18,999	631	20	950	319	5,855	17
18											18
19	Tile flooring			1996	991	25	20	50	25	300	19
20	Curtains			1996	3,187	284	20	159	(125)	888	20
21	Mini blinds			1996	358	32	20	18	(14)	101	21
22	Concrete parking lot			1996	1,250	74	20	63	(11)	341	22
23	Paving and lining parking lot			1996	8,325	494	20	416	(78)	2,115	23
24											24
25	Electrical box			1997	3,777	97	20	189	92	945	25
26	Medicare survey			1997	1,543		20	77	77	347	26
27	Windows			1997	1,640	42	20	82	40	369	27
28	Screen patio			1997	8,369	215	20	418	203	1,811	28
29	Seal coat parking lot			1997	675	60	20	34	(26)	145	29
30											30
31	Landscaping			1998	4,553	280	15	304	24	959	31
32	Remodeling			1998	1,822	47	20	91	44	319	32
33	Siding & windows			1998	39,885	1,023	20	1,994	971	6,979	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Outdoor sign	1999	$ 1,036	$ 181	20	$ 52	$ (129)	$ 156	37
38	Sprinkler heads	1999	2,187	56	20	109	53	327	38
39	Handicapped bathrooms	1999	23,785	800	20	973	173	2,919	39
40	Nurse call system	1999	3,648	94	20	182	88	546	40
41									41
42	Roof	1999	21,735	557	20	1,087	530	3,261	42
43	Fencing	1999	2,777	237	20	139	(98)	417	43
44	Windows	1999	1,250	32	20	63	31	189	44
45									45
46	Garage & patio	1999	15,560	399	20	778	379	2,334	46
47									47
48	Windows	2000	1,233	32	20	62	30	93	48
49	Key system	2000	1,080	34	20	54	20	81	49
50	Resurface parking lot	2000	1,950	193	20	98	(95)	147	50
51									51
52	Kitchen remodeling	2001	2,152	40	20	54	14	54	52
53	Air compressor	2001	5,900	108	20	148	40	148	53
54	Carpet	2001	1,221	9	20	31	22	31	54
55	New roof - shed	2001	1,320	7	20	33	26	33	55
56	Remodel skill units	2001	5,897	48	20	147	99	147	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 653,374	$ 24,645		$ 26,510	$ 1,865	$ 479,864	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 78,634	$ 5,269	$ 7,276	$ 2,007	10	$ 28,414	71
72	Current Year Purchases	56,371	8,054	2,819	(5,235)	10	2,819	72
73	Fully Depreciated Assets	98,890					98,890	73
74	Home office allocation			5,783	5,783			74
75	TOTALS	$ 233,895	$ 13,323	$ 15,878	$ 2,555		$ 130,123	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility van	89 Ford Van	1993	$ 10,795	$	$	$		$ 10,795	76
77	Facility van	Hossler Van	1999	40,785	7,831	10,196	2,365	4	25,490	77
78										78
79										79
80	TOTALS			$ 51,580	$ 7,831	$ 10,196	$ 2,365		$ 36,285	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 963,849	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,799	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,584	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,785	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 646,272	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5			Home office allocation		2,450			5
6								6
7	TOTAL				$ 2,450 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,192 Description: Dishwasher $769: Laundry equip $3,744; Copier $1,043; Nursing equip $932; Home office alloc $1,706
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☒ NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,324,639	$ 1,324,639	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	271,438	271,438	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,787	6,787	6
7	Other Prepaid Expenses	5,446	5,446	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,608,310	$ 1,608,310	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	42,621	25,000	13
14	Buildings, at Historical Cost	665,231	653,374	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	287,741	285,475	16
17	Accumulated Depreciation (book methods)	(711,342)	(646,272)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached schedule 17A	717,811	717,811	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,002,062	$ 1,035,388	24

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,170,631	$ 1,170,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,772	36,772	30
31	Accrued Taxes Payable (excluding real estate taxes)	245	245	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,885	8,885	32
33	Accrued Interest Payable	9,051	9,051	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule 17A	68,384	68,384	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,293,968	$ 1,293,968	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,373	24,373	39
40	Mortgage Payable	981,596	981,596	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,005,969	$ 1,005,969	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,299,937	$ 2,299,937	46

25	TOTAL ASSETS (sum of lines 10 and 24)	$ 2,610,372	$ 2,643,698	25

47	TOTAL EQUITY(page 18, line 24)	$ 310,435	$ 343,761	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 2,610,372	$ 2,643,698	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 163,020	1
2	Restatements (describe):		2
3	Prior period adjustment	(15,207)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 147,813	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	162,622	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 162,622	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 310,435	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,861,163	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,861,163	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,780	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 3,780	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	391,713	31
32	Health Care	644,716	32
33	General Administration	447,233	33
	B. Capital Expense		
34	Ownership	176,771	34
	C. Ancillary Expense		
35	Special Cost Centers	4,658	35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,702,321	40
41	**Income before Income Taxes (line 30 minus line 40)****	162,622	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 162,622	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 1,864,943	30

Entity files as cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,451	2,451	$ 44,946	$ 18.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,183	4,470	67,711	15.15	3
4	Licensed Practical Nurses	10,307	10,633	116,243	10.93	4
5	Nurse Aides & Orderlies	33,198	34,265	291,874	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,764	1,933	17,754	9.18	8
9	Activity Director	2,048	2,048	15,633	7.63	9
10	Activity Assistants					10
11	Social Service Workers	4,160	4,160	29,252	7.03	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,367	9.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,327	10,610	68,110	6.42	15
16	Dishwashers					16
17	Maintenance Workers	2,521	2,521	24,210	9.60	17
18	Housekeepers	10,757	10,989	66,699	6.07	18
19	Laundry	3,229	3,293	18,321	5.56	19
20	Administrator	2,080	2,080	51,967	24.98	20
21	Assistant Administrator					21
22	Other Administrative	451	451	86,079	190.86	22
23	Office Manager					23
24	Clerical	1,300	1,301	22,747	17.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan	2,183	2,183	26,790	12.27	32
33	Other(specify)					33

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	17	$ 653	L1, C3	35
36	Medical Director	Monthly	7,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	L10, C3	39
40	Physical Therapy Consultant	33	1,920	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	90	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant	13	780	L12, C3	45
46	Other(specify)				46
47	Rehabilitation Consultant	11	690	L10a, C3	47
48					48
49	TOTAL (lines 35 - 48)	76	$ 12,833		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

34	TOTAL (lines 1 - 33)	91,039	95,468	$ 968,703 *	$ 10.15	34	SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Shaw	Administrator	0%	$ 51,967
Home Office Allocations			
Mark Petersen	Administrative	0%	26,045
James Petersen	Administrative	100%	60,034
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,046

B. Administrative - Other

Description	Amount
Management Fees	$ 47,891
Management Fees eliminated in Column 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 47,891
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder	Legal	$ 2,494
Mary Albert-Frits	Legal	1,379
Duane Morris & Hecksher LLP	Legal	930
Ginoli & Co	Accounting	1,120
Altschuler Melvoin & Glasser	Accounting	3,500
ADP	Payroll services	6,701
Mid America Programming	Computer consultation	1,500
AHCA Facilitator	Computer consultation	340
America Online	Computer services	225
See attached Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,189

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,210
Unemployment Compensation Insurance	8,755
FICA Taxes	62,808
Employee Health Insurance	30,616
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k) Retirement Plan	2,031
Employee morale	9,157
Life Insurance	535
Home office allocation	12,096
TOTAL (agree to Schedule V, line 22, col.8)	$ 159,208

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	715
Health Care Worker Background Check	
(Indicate # of checks performed 14)	168
HCFA Laboratory Program	300
Illinois Health Care Assn Dues	3,722
Miscellaneous dues	521
Miscellaneous licenses	5
Miscellaneous subscriptions	27
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,458

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	z
Seminar Expense	9,611
Home office allocation	1,267
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,878

*** Attach copy of IMRF notifications** ****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn - $ 3,722**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **37,230**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,780**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	88,477	8,231	653	97,361	0	97,361	21	97,382
2. Food Pu	0	85,781	0	85,781	0	85,781	-3,780	82,001
3. Housek	66,699	7,860	0	74,559	0	74,559	0	74,559
4. Laundry	18,321	6,470	0	24,791	0	24,791	0	24,791
5. Heat an	0	0	49,678	49,678	0	49,678	389	50,067
6. Mainter	24,210	33,704	1,629	59,543	0	59,543	476	60,019
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	197,707	142,046	51,960	391,713	0	391,713	-2,894	388,819
9. Medical	0	0	7,800	7,800	0	7,800	0	7,800
10. Nursin	565,318	17,943	900	584,161	0	584,161	0	584,161
10a. Thera	0	0	2,700	2,700	0	2,700	0	2,700
11. Activiti	15,633	520	3,008	19,161	0	19,161	0	19,161
12. Social	29,252	862	780	30,894	0	30,894	4	30,898
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	610,203	19,325	15,188	644,716	0	644,716	4	644,720
17. Admin	138,046	0	47,891	185,937	0	185,937	-47,891	138,046
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	18,189	18,189	0	18,189	3,270	21,459
20. Fees,	0	0	5,239	5,239	0	5,239	219	5,458
21. Clerica	22,747	5,030	11,930	39,707	0	39,707	9,405	49,112
22. Emplo	0	0	147,112	147,112	0	147,112	12,096	159,208
23. Inservi	0	0	1,218	1,218	0	1,218	43	1,261
24. Travel	0	0	9,611	9,611	0	9,611	1,267	10,878
25. Other	0	0	2,356	2,356	0	2,356	1,413	3,769

26.	Insura	0	0	37,864	37,864	0	37,864	1,753	39,617
27.	Other	0	0	0	0	0	0	0	0
28.	Total (	160,793	5,030	281,410	447,233	0	447,233	-18,425	428,808
29.	Total (	968,703	166,401	348,558	1,483,662	0	1,483,662	-21,315	1,462,347
30.	Depre	0	0	45,799	45,799	0	45,799	6,785	52,584
31.	Amorti	0	0	0	0	0	0	0	0
32.	Interes	0	0	115,296	115,296	0	115,296	931	116,227
33.	Real E	0	0	9,190	9,190	0	9,190	0	9,190
34.	Rent -	0	0	0	0	0	0	2,450	2,450
35.	Rent -	0	0	6,486	6,486	0	6,486	1,706	8,192
36.	Other	0	0	0	0	0	0	0	0
37.	Total (	0	0	176,771	176,771	0	176,771	11,872	188,643
38.	Medic	0	0	0	0	0	0	0	0
39.	Ancilla	0	0	0	0	0	0	0	0
40.	Barbe	0	0	0	0	0	0	0	0
41.	Coffee	0	0	0	0	0	0	0	0
	42	0	0	37,230	37,230	0	37,230	0	37,230
43.	Other	0	0	4,658	4,658	0	4,658	-4,658	0
44.	Total S	0	0	41,888	41,888	0	41,888	-4,658	37,230
45.	Grand	968,703	166,401	567,217	1,702,321	0	1,702,321	-14,101	1,688,220

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	1,324,639	1,324,639
2. Cash - F	0	0
3. Account	271,438	271,438
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	6,787	6,787
7. Other Pr	5,446	5,446
8. Account	0	0
9. Other (s	0	0
10. Total c	1,608,310	1,608,310
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	42,621	25,000
14. Buildin	665,231	653,374
15. Leaseh	0	0
16. Equipm	287,741	285,475
17. Accum	-711,342	-646,272
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	717,811	717,811
24. Total L	1,002,062	1,035,388
25. Total A	2,610,372	2,643,698
CURRENT LIABILITIES		
26. Accour	1,170,631	1,170,631

27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	36,772	36,772
31. Accrue	245	245
32. Accrue	8,885	8,885
33. Accrue	9,051	9,051
34. Deferre	0	0
35. Federa	0	0
36. Other C	68,384	68,384
37. Other C	0	0
38. Total C	1,293,968	1,293,968
LONG TERM LIABILITES		
39.Long-Te	24,373	24,373
40.Mortgag	981,596	981,596
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	1,005,969	1,005,969
46.Total Li	2,299,937	2,299,937
47.Total Ec	310,435	343,761
48.Total Li	2,610,372	2,643,698

	Balance per Medicaid Trial Balance
1. Gross F	1,861,163
2. Discour	0
Subtota	1,861,163
4. Day Ca	0
5. Other C	0
6. Therapy	0
7. Oxygen	0
Subtota	0
9. Paymer	0
10. Other	0
11. Nurses	0
12. Gift an	0
13. Barber	0
14. Non-P	3,780
15. Telepl	0
16. Rental	0
17. Sale o	0
18. Sale o	0
19. Labora	0
20. Radiol	0
21. Other	0
22. Laund	0
Subtot	3,780
24. Contril	0
25. Interes	0

	Subtot	-
27.	Other	0
28.	Other	0
	Subtot	-
30.	Total F	1,864,943
31.	Gener	391,713
32.	Health	644,716
33.	Gener	447,233
34.	Owner	176,771
35.	Specia	4,658
35.	Provid	37,230
37.	Other	0
40.	Total E	1,702,321
41.	Incom	162,622
42.	Incom	0
43.	Net In	162,622

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Robings Manor Nursing** **04:01 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-14,101	equal to	-14,101	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	116,227	equal to	116,227	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	9,190	equal to	9,190	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	52,584	equal to	52,584	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,450	equal to	2,450	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,192	equal to	8,192	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	2,700	equal to	2,700	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	391,713	equal to	391,713	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	644,716	equal to	644,716	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	447,233	equal to	447,233	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	176,771	equal to	176,771	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	4,658	equal to	4,658	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	37,230	equal to	37,230	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	565,318	equal to	565,318	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	15,633	equal to	15,633	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	29,252	equal to	29,252	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	88,477	equal to	88,477	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	24,210	equal to	24,210	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	66,699	equal to	66,699	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	18,321	equal to	18,321	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	138,046	equal to	138,046	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	22,747	equal to	22,747	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	968,703	equal to	968,703	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1

Dietary Consultant		653	< or = to	653	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director		7,800	< or = to	7,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors		900	< or = to	900	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant		0	< or = to	3,008	-3,008	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant		780	< or = to	780	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		138,046	equal to	138,046	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		47,891	equal to	47,891	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.		18,189	equal to	18,189	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes		159,208	equal to	159,208	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..		5,458	equal to	5,458	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav		10,878	equal to	10,878	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees		37,230	equal to	37,230	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None		< or = to	12,096	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None		equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training		0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided		0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		-6,581	equal to	-6,581	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance		1,005,969	equal to	1,005,969	0	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual		8,885	equal to	8,885	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land		25,000	equal to	25,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost		653,374	equal to	653,374	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost		285,475	equal to	285,475	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.		646,272	equal to	646,272	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity		310,435	equal to	310,435	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)		162,622	equal to	162,622	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost		0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet		2,610,372	equal to	2,610,372	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1